Insurance

Auto Insurance		
SB 08-011 *(Enacted)* Trauma Care Funding	**SB 08-211** *(Postponed Indefinitely)* Mandatory Medical Payments Coverage	**HB 08-1009** *(Postponed Indefinitely)* Emergency Medical Care Coverage Auto Insurance
Health Insurance		
SB 08-135 *(Enacted)* Health Insurance Standardized Benefits Card	**HB 08-1311** *(Postponed Indefinitely)* Small Group Limited Health Benefit Plan	**HB 08-1327** *(Postponed Indefinitely)* Access Affordable Health Insurance Out of State
HB 08-1385 *(Enacted)* Increased Health Insurance Transparency	**HB 08-1390** *(Enacted)* CoverColorado Long-term Funding	**HB 08-1393** *(Enacted)* Consumer Health Care Transparency Act
HB 08-1410 *(Enacted)* Preventive Coverage Colorectal Cancer		
Health Care Reform		
SB 08-217 *(Enacted)* Centennial Care Choices		
Regulatory Changes to Insurance		
HB 08-1228 *(Enacted)* Insurance Responsibility Unfair Business Practices	**HB 08-1389** *(Enacted)* Fair Accountable Insurance Rates	**HB 08-1407** *(Enacted)* Penalty Unreasonable Conduct Insurers
Unemployment Insurance		
HB 08-1180 *(Enacted)* Unemployment Insurance Benefits Active Military Transfer		
Workers' Compensation		
SB 08-241 *(Enacted)* Workers' Comp Apportion Multiple Devices		

Auto Insurance

In 2003, Colorado converted from a no-fault automobile insurance system to a tort system. Under no-fault, vehicle owners were covered by their own insurance policies for reimbursement for personal injury sustained in an accident. Trauma care providers were able to collect for care from the motorist's insurer regardless of fault. Under the tort system, a person must prove that the other party involved was at fault in order to receive payment for damages. This can create a delay in payments to trauma care providers. At-fault drivers without health coverage are responsible for their own trauma care costs. If the driver is unable to pay, trauma care providers may not be reimbursed for their services. In response to the issue of reimbursement to trauma care providers, several bills were considered in the 2008 session.

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Senate Bill 08-011 requires insurance companies to include medical payments coverage of at least $5,000 on motor vehicle policies beginning January 1, 2009. A policy may be issued without medical payments coverage only if the policyholder rejects the coverage in writing, or in the same medium in which the application for the policy was taken.

The insurance company must maintain proof of the policyholder's rejection of medical payments coverage for three years. If the insurance company fails to offer the coverage or to maintain documentation of the rejection, the policy is assumed to include medical payments coverage in the amount of $5,000. Motorcycles, motorscooters, motorbicycle, motorized bicycle, toy vehicle, snowmobiles, or any vehicle designed primarily for the use off the road or on rails, and persons who self-insure, are exempted from the requirements.

The bill specifies the following order of priority in which persons providing medically necessary and accident-related trauma care or medical care are to be paid benefits:

- licensed ambulances or air ambulances;
- trauma physicians;
- level IV or V trauma centers; and
- level I, II or III trauma centers or regional pediatric trauma centers.

Any remaining benefits are to be held and used to pay claims of trauma care providers listed above for no more than 30 days. After 30 days, the remaining benefits may be used to pay any other claims for reimbursement submitted by other providers.

Two other bills addressed the trauma care providers, but were postponed indefinitely. **House Bill 08-1009**, recommended by the Health Care Task Force, would have required insurance companies to include emergency medical coverage of at least $15,000 on all motor vehicle policies beginning January 1, 2009. The coverage would have provided at least $15,000 per person in any one accident for all medically necessary and accident-related emergency medical care expenses regardless of fault. Insurance companies would have paid claims from this coverage to emergency medical or trauma care providers including first responders, trauma physicians, trauma centers, and hospital emergency rooms.

Senate Bill 08-211 would have required all automobile insurance policies issued on or after January 1, 2009, to include medical payments coverage of at least $10,000 for the payment of all medically necessary and accident-related health care expenses for bodily injury arising out of the ownership, maintenance, or use of the motor vehicle. Payment would have been made to a first responder, licensed or certified hospital, or licensed health care provider, for medically necessary and accident-related health care services provided to the injured person within five years after the accident. If an insurer failed to include medical payments coverage in a policy, the policy would have been presumed to have included the minimum medical payments coverage.

The medical payments coverage benefits would have been paid to persons or entities providing medically necessary and accident-related health care services in priority order to first responders, then to hospitals or trauma centers. Any remaining benefits would have been paid to

providers of subsequent health care services. Medical payments coverage under the bill would have paid before health insurance and could have applied to any coinsurance or deductible amount required by a health insurance plan. The bill specified reimbursement rates for medical services provided.

Health Insurance

The General Assembly considered a variety of health bills legislation during the 2008 session. Major topics addressed include increasing transparency, allowing Colorado residents to purchase out-of-state health insurance benefit plans, requiring small employer health insurance carriers to provide a limited health benefit plan, and a request for information for a value benefit plan which will be available to all Colorado residents.

Two bills seek to increase health care transparency. **House Bill 08-1393** requires the Insurance Commissioner to work with the Colorado Hospital Association (CHA) to include information about charges for the 25 most common inpatient procedures in the hospital report card. Hospitals must report the data to the CHA annually and the CHA must make the information available on its website by August 1, 2009. By March 1, 2009, and annually thereafter, health insurance carriers must submit certain information to the Department of Regulatory Agencies, Division of Insurance, with regard to the 25 most common inpatient procedures. The Division of Insurance must post that information on its website. **House Bill 08-1385** requires the Insurance Commissioner to implement and maintain a consumer guide to health benefits coverage on the Division of Insurance website. The website must include information on each carrier, a link to the division's complaint form and index of complaints, and other information the commissioner determines to be useful to consumers.

House Bill 08-1311, postponed indefinitely, would have required small employer benefit health insurance carriers to offer a limited benefit health plan. The bill outlined two limited health benefit plans: the first option was limited to $35,000 in total coverage per person, and did not allow for a deductible, but could require co-payments. The second option was limited to $50,000 in total coverage per person, but could include a deductible and co-payments.

House Bill 08-1327, postponed indefinitely, would have allowed Colorado residents to purchase health insurance from companies that were not licenced in Colorado, but whose insurance products were lawfully sold in other states. The bill stated that out-of-state insurance companies selling insurance products in Colorado would have been subject to regulation by Colorado's Insurance Commissioner in Colorado with regard to enforcement of contractual benefits under the health insurance product.

House Bill 08-1390 establishes a new funding structure for the CoverColorado program. CoverColorado is a non-profit organization that provides major medical health insurance to Colorado residents who have been denied access to health insurance because of a pre-existing medical condition. Currently, CoverColorado is funded through member premiums and the Unclaimed Property Trust Fund (an approximate 50/50 split). In the event of a fund shortfall, a carrier

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assessment fee is assessed against insurers. With implementation of this act, beginning January 1, 2009, the new funding structure is as follows:

- 50 percent from premiums, grants, and donations;
- 25 percent from the Unclaimed Property Trust Fund; and
- up to 25 percent from special fees assessed against insurers.

Under the act, the CoverColorado Board is required to determine the amount of the special fees assessed against insurers in the event of a fund shortfall. The Insurance Commissioner has the authority to enforce payment of the special fees levied against insurers. If the program experiences unexpected growth in enrollment or claims expenses, the board may request additional funding from the Unclaimed Property Trust Fund.

The act also establishes an 11-member CoverColorado Long-term Funding Task Force to develop a 10-year funding plan for the program. The plan must be submitted to the General Assembly by March 31, 2009. The Long-Term Funding Task Force repeals July 1, 2009.

The program is set to repeal July 1, 2017, but prior to that date, the State Auditor must conduct or contract for a review and evaluation of the efficacy of the funding structure and report its findings to the General Assembly by January 1, 2017.

In order to increase efficiency and incorporate health information technology, **Senate Bill 08-135** requires regulated health insurance carriers to issue to their members, a card or other device containing standardized benefit information that can be electronically scanned. The minimum information to be included is:

- covered person's name and the applicable plan number;
- co-payment and deductible amounts;
- an indication of whether the plan is regulated by the state;
- contact information for carrier or plan administrator.

The act stipulates that all insurance carriers must issue the standardized, printed card by July 1, 2009, for new and renewal members and by July 1, 2010, for all plan members. In addition, the act requires the Insurance Commissioner to convene a working group within 30 days after the effective date to develop specifications for the card or device and to adopt rules with specifications for the printed card. Insurance carriers will have two years after the effective date of the rules to implement the standardized electronic coverage technology. Licensed or certified hospitals and physicians must use the standardized, printed card provided to covered persons. An insurance carrier or provider located in a rural area of the state may apply to the commissioner for an extension of any of the deadlines imposed if meeting a particular deadline would impose a financial hardship on the rural carrier or provider.

Addition of a health insurance mandate. **House Bill 08-1410** mandates that most health insurance plans cover screening tests for colorectal cancer with cost sharing limited to 10 percent of the cost of screening. In order for the act to go into effect, the commission on health insurance

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must evaluate the effects of the addition of mandating colorectal cancer screenings on health insurance premiums and provide a report to the Insurance Commissioner by December 31, 2008 with the results of the evaluation.

Health Care Reform Effects on Health Insurance

In the 2006 legislative session, Senate Bill 06-208 established the Blue Ribbon Commission on Health Care Reform with specific requirements to review the health insurance products available in the Colorado market. The Blue Ribbon Commission on Health Care Reform presented its report to the House and Senate Health and Human Services committee in January 2008. As a result of the recommendations from the commission, **Senate Bill 08-217** requires the Department of Health Care Policy and Financing, in coordination with the Division of Insurance and a panel of experts, to prepare a request for information (RFI) from health insurance companies and other interested parties including the state of Colorado to design a new health insurance product known as a value benefit plan. The act states that the Governor will appoint the panel of experts which is to include persons experienced in implementing and managing of health benefit plans, and persons experienced with disability and long-term care issues. If the Governor fails to appoint members of the panel by July 1, 2008, the Speaker of the House of Representatives and the President of the Senate will each appoint five members to the panel of experts by July 15, 2008. The RFI will be sent out July 1, 2008. The value benefit plans (VBPs), at a minimum, must:

- offer benefits that approximate 80 percent of the actuarial value of the preferred provider organization plan offered to state employees;
- include benefits for participation in wellness programs and incentives for participation in healthy behavior;
- provide the lowest-level of benefits that may be offered in the state's individual market;
- specify an adequate network of providers;
- encourage the use of health information technology, telemedicine, and internet-based health care education materials and tools;
- encourage the use of pay-for-performance systems for reimbursing health care providers;
- encourage the use of regional networks of hospitals, physicians, community health centers, and other safety net providers;
- limit rate setting characteristics to those based on age and geographic location of the policyholder with optional coverage choices for consumers;
- be offered statewide and issued to any Colorado resident eligible; and
- allow payment through a state-paid premium subsidy.

The department, in collaboration with the division and the panel of experts, must provide a progress report to the House and Senate Health and Human Services Committees by December 15, 2008, on the status of the RFI. On or before March 1, 2009, the department, in collaboration with the division and the panel of experts, must provide a final report on the RFI to the legislative committees. The final report must include actuarial projections, research potential cost savings, and any legislative recommendations.

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The House and Senate Health and Human Services committees will review the final report and decide whether to proceed with the Centennial Care Choices Program (CCCP), whether to create a premium subsidy program, and whether to create a permanent funding source for the program.

If the General Assembly enacts legislation to create the CCCP, and if a funding source is identified and approved, the department may develop a request for proposals (RFPs) to be issued to interested insurance carriers for the purpose of developing plan designs for the VBP. Prior to issuing a RFP, the department, the division, and the panel of experts, must develop a benchmark price or affordability standard for VBPs to ensure eligible individuals can afford the product. The RFP must meet the parameters of the RFI. An insurance carrier does not need to have a certificate of authority to submit an RFI or RFP , but they are required to have a certificate of authority to offer an approved VBP.

Regulatory Changes to Insurance

A few bills in the 2008 session addressed the regulatory structure of insurance. Current rate regulation law provides that, except for workers' compensation and assigned risk motor vehicle insurance, prior approval of rates by the Division of Insurance is not required. The Commissioner of Insurance does require pre-approval of Medicare supplemental insurance. Insurance companies file rates for health, other than Medicare Supplemental Insurance, with the division that become effective immediately or at a future date specified by the filer. The commissioner may disapprove a filing at any time if it is not in compliance with the law.

House Bill 08-1389 creates the Fair Accountable Insurance Rates Act for health insurance rates that take effect on or after January 1, 2009. Rate filings that include rate increases, must be filed with the commissioner at least 60 days prior to the proposed use of the rates. If the commissioner does not approve or disapprove the rates filed within a 60-day period, the insurance company may implement and reasonably rely on the rates on the condition that the commissioner may require correction of any deficiencies in the rate filing upon later review if the rate charged is excessive, inadequate, or unfairly discriminatory.

The commissioner is required to disapprove a rate increase if any of the following apply:

- benefits provided are not reasonable in relation to the premiums charged;
- the rate increase is excessive, inadequate, unfairly discriminatory, or do not comply with the provisions of Title 10, C.R.S., dealing with insurance;
- Colorado claims experience and data, when available, do not justify the rate increase; or
- the rate filing is incomplete.

The commissioner may also consider the expected benefits ratio for a health benefit plan, defined as the ratio of the value of the actual benefits, not including dividends, to the value of actual premiums not reduced by dividends, over the entire period for which rates are computed to provide coverage.

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The act includes a penalty of not more than $10,000 per violation for a person or organization that knowingly withholds information that will affect the rates or premiums or provides false or misleading information to the commissioner or any statistical agent, advisory organization, or carrier. However, if a person or organization is found to have willfully withheld information or provided false or misleading information, a penalty of not more than $25,000 may be assessed per violation.

The act also allows the Consumer Insurance Council to issue an annual consumers' choice award to a health insurance carrier that has achieved the lowest rates, highest benefit ratio, and lowest complaint ratio for each line of insurance. Finally, under the new law, insurance carriers must submit certain cost information to the commissioner for each calendar year by June 1.

House Bill 08-1407 prohibits the unreasonable delay or denial of payment of a claim for benefits owed by an insurance company, and provides remedies for claimants, including a new cause of action. If an action brought under this bill is found to be frivolous, the court shall award costs and attorney fees to the defendant in the action. The bill exempts workers' compensation, life and title insurance from its provisions. It increases the monetary penalties the Commissioner of Insurance can impose on insurance companies and agents for violations of law. It prohibits an insurance contract from giving the plan administrator sole discretion in determining eligibility for benefits. The bill expands the definition of restitution to include costs and expenses for lost time from work and attorney fees.

House Bill 08-1228 authorizes the Commissioner of Insurance to collect restitution from an insurance producer (agent) or insurer for violating insurance laws or rules. Further, insurers are financially responsible for the unfair business practices of a producer authorized to sell its products if the insurer knew or should have known of the unfair business practices.

Unemployment Insurance

House Bill 08-1180 extends unemployment insurance benefits to spouses of military personnel who are transferred as part of their military responsibilities. The Division of Employment and Training within the Department of Labor and Employment must maintain records of claims made and amounts awarded to individuals who quit a job to relocate with an active-duty military spouse who is transferred. The division must annually report this information to the House Business Affairs and Labor Committee and the Business, Labor, and Senate Technology Committee. The provision allowing individuals who relocate with a military spouse to receive unemployment benefits repeals on July 1, 2018.

Workers' Compensation

Senate Bill 08-241 changes the Workers' Compensation Act of Colorado to allow claimants who have lost a body part from a work-related injury to receive more than one prosthetic. The bill also clarifies the fee schedule for all medical, surgical, hospital, dental, nursing, and vocational rehabilitation to apply to any party charged for services in connection with a workers' compensation claim.